CALIFORNIA SPORTS & SPINE INSTITUTE
info@CSSILA.COM

Referral Form

tel: (626) 460-1096 • fax: (888) 425-9079 • tel: (818) 338-6860
info@californiasportsandspine.com

☐ 51 N. 5th Ave, #301
Arcadia, CA 91006

☐ 317 S. Brand Blvd, Suite A-104
#301 Glendale, CA 91204

Please complete the form, then fax/e-mail along with the last office note, EMG/NCS, MRI, and any other pertinent imaging studies. Our Office will contact the patient for an appointment.
You may also call our office directly. Office Hours: 9:00 am to 5:00 pm.

☐ **Maxim Moradian, MD, QME, DABPMR, CAQSM, DABPM, DABRM**
☐ **Revik Vartanian, DO, DABPMR**

Patient Information:

Patient Name:_____ D.O.B. ___/___/_____

SS#_____ Phone#: _____

E-mail: _____

Address: _____ City: _____ Zip: _____

Patient Insurance: _____
(Please include copy of front & back of insurance, Driver's insurance)

Referring Diagnosis: _____

Testing (Past 6 Months): _____

☐ X-Ray ☐ MRI ☐ CT Scan ☐ EMG/NCS ☐ Ultrasound ☐ Other: _____
(Please include copy of testing reports if possible)

Referring Provider's Name: _____

Referring Provider Ph:_____ E-mail: _____ Fax#_____

Office Contact Person: _____ Sender's Name _____

Please Check Preferences:

☐ **Consult & Treat** ☐ **Consult & Return with Recommendations** ☐ **Electrodiagnostic Testing (EMG/NCS)**
☐ **Injection Series (Must complete the Following)** ☐ **Spinal Cord Stimulation Consult**

☐ **Lumbar**	**Level(s)**_____	**Circle One: (Left • Right)**
☐ **Cervical**	**Level(s)**_____	**Bilateral Circle One: (Left • Right)**
☐ **Thoracic**	**Level(s)**_____	**Bilateral Circle One: (Left • Right)**
☐ **Nerve Block**	**Level(s)**_____	**Bilateral Circle One: (Left • Right)**
☐ **Joint**	**Specify:**_____	**Bilateral**

After injection, patient to follow up with: ☐ Referring Provider ☐ CSSI